DEPARTMENT OF DEVELOPMENTAL SERVICES
ABI/MFP RESIDENTIAL
STATEMENT OF OCCUPANCY

DDS REGION:	**FISCAL YEAR:**
PROVIDER:	☐ **INITIAL SOO**
VENDOR CODE: VC	☐ **AMENDMENT NUMBER:**
MASTER AGREEMENT: DDSALTR(A-G)(H-M)(N-Z)0000000000	**DOC ID:**

This Statement of Occupancy (SOO) is issued under the terms of the Adult Long Term Residential (ALTR) Master Agreement.

This Statement of Occupancy is subject to the Adult Long Term Residential Master Agreement, which includes the Commonwealth Terms and Conditions for Human and Social Services, Standard Contract Form, the RFR and the Provider's Response to the RFR and any clarifications/negotiated terms. Occupancy rates and expenditures as outlined in this SOO and attachments are subject to change by the Department in consultation with the provider. A SOO must be signed by the Provider and the Agency before occupancy costs can be reimbursed.

1. The Agency will reimburse the Provider for ABI/MFP services which are rendered in accordance with the Adult Long Term Residential Master Agreement. Billing shall be done through the Virtual Gateway and the Enterprise Invoice Service Management System, in accordance with Agency billing guidelines.
2. The provider will only be reimbursed for occupancy costs up to the Estimated Expenditure Amount noted in this SOO.
3. The Estimated Expenditure Amount for occupancy costs outlined in this SOO is the estimate of the site rates as calculated on the attached ABI Residential Occupancy Worksheet. The rate will be converted to a monthly accommodation rate for billing purposes.
4. The information provided on the attached Occupancy Worksheet is a true and accurate representation of costs incurred and reported in the UFR for the listed sites/program locations. All expenses listed as Adjustments to UFR were actually incurred to support the operation of the sites listed. The rate/s for new sites that fall under the New Site Occupancy rate setting process was set by the Executive Office of Health and Human Services. The offsets include all known offsets that will be applied to defray total occupancy costs. If additional offset funding becomes available during the course of this engagement, the Worksheet will be revised and additional steps taken to reconcile these additional offset amounts.
5. All funding for this Statement of occupancy is subject to appropriations. An amended SOO must be completed and filed when there is a material change to the Estimated Expenditure Amount. Once signed, the expected expenditure will be entered in the Massachusetts Management Accounting and Reporting System, MMARS. DDS can amend this SOO, after consultation with the provider, if able to demonstrate that occupancy costs are excessive and not justified by past expenditures.
6. Any work done without authorization pursuant to this SOO and the attached occupancy worksheet will be considered in violation of the ALTR Master Agreement and this SOO.
7. Documents additional to this SOO that are not inconsistent to the terms of the SOO or the Master Agreement may be required by the Agency and will become part of this Statement of Occupancy. These documents may include emails from the Agency authorizing minor changes to occupancy costs that do not impact the estimated expenditure amount.
8. The terms of this SOO may be terminated by the Agency upon written notice at any time during the life of the Master Agreement contract.
9. This Statement of Occupancy shall cover services starting on: _____, and shall terminate on: _____.

Department of Developmental Services
ABI/MFP Residential
Statement of Occupancy

Provider Information **Doc ID:**	**Department Information**
Provider Name: **Provider Address:**	**Department Name:** Department of Developmental Services **Billing Address:**
Provider's Contact Person for this Statement of Work:	**Department's Contact Person for this Statement of Work:**
Telephone: **Email:**	**Telephone:** **Email:**
Attached to this SOO is the ABI Residential Occupancy Worksheet. **Expected Expenditure Amount: $** **Monthly Accommodation Rate: $**	
Acceptance The Parties hereby acknowledge the terms of this Statement of Work.	
Name of Provider Authorized Signatory:	**Name of Agency Authorized Signatory:**
Signature:	**Signature:**
Title:	**Title:**
Date:	**Date:**